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THE ALBANIA HEALTH SECTOR GOVERNANCE STUDY

TECHNICAL BRIEF

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1. INTRODUCTION

The Government of Albania (GOA) has recently enacted a series of laws - the Basic Health Care Law, Public Health Law, and the Law on Health Insurance - that are intended to help reform the health care system and provide greater access to affordable, quality health care for all Albanians. Implementation of this legislative framework, which defines the roles and functional responsibilities of the Ministry of Health (MOH), Health Insurance Institute (HII) and other health sector institutions requires sound institutional governance.

USAID/Albania's five-year Enabling Equitable Health Reforms (EEHR) Project is supporting the GOA to implement this legislative framework to advance the health reform process. EEHR undertook a Governance Review, together with an in-depth institutional review of the Health Insurance Institute (HII) and an assessment of the capacity of the health sector Monitoring and Evaluation (M&E) function, in order to identify ways to best support the GOA. This Technical Brief is a summary of *The Albania Health Sector Governance Study, Technical Report* (Chee and Jeffers, USAID Enabling Equitable Health Reforms Project, 2011.) which assesses the state of the health reform process, areas of success and barriers to effective implementation and recommends concrete measures to build institutional managerial capacity and improve governance. To frame the scope of the review, the review team, together with the EEHR team, agreed to focus on four primary areas that are most critically affected by the health sector reforms, namely:

- Health system governance and leadership
- Standards and processes to ensure and improve quality
- Hospital organization, operations and management
- Financing and health insurance

2. APPROACH AND METHODS

The review team drew upon the CAR Framework developed to guide discussions of governance. The CAR Framework identifies three characteristics that influence whether government authorities effectively carry out their responsibilities:

- Capability
- Accountability
- Responsiveness

Using this framework, the review examines whether the institutions responsible for implementing the new legislation have the capacity to carry out their assigned functions, whether the mechanisms for holding them responsible are being implemented effectively, and whether there are processes and incentives to identify and respond to concerns of relevant stakeholders.

Prior to in-country assessment, the team conducted a desk review of key documents including relevant health sector Laws, Decisions, Orders, health sector reviews, strategy documents, reports of previous USAID projects, contracts between HII and health facilities, and information on organizational structures of key institutions. The review team then conducted interviews in-country to validate understanding of existing laws and mandates; confirm current practices and the extent to which they differ from mandates, including institutional roles and functions not being carried out; and

gather input on recommendations for improvement. Finally, the team visited two regions to gain an understanding of the health system at all levels and to identify potential opportunities for interventions that could be piloted at the regional level.

3. FINDINGS

3.1 HEALTH SYSTEM GOVERNANCE AND LEADERSHIP

The MOH is charged with providing overall vision, leadership and governance for health care in Albania. The Basic Health care law states that the MOH "prepares health care system strategy, which includes policies and appropriate health programs and national treatment protocols." The MOH has developed the National Health Strategy 2007 – 2013 which presents the sector's mission statement, strategic priorities, policies, tasks for policy implementation and budget implications and is used by health institutions as the basis for planning.

While the MOH is both by law and position the organization charged with developing and implementing the national health strategy, it has yet to establish its authority and provide leadership for the sector. Positions of authority within the MOH have generally been given to minority political parties within the governing coalition, giving it little leverage to influence the national priorities of the GOA. In addition, MOH leadership has suffered from frequent turnover with four ministers serving in the span of five years. The impact of this is magnified by the fact that politically-appointed positions within the MOH include heads of Directorates and Sectors and even Hospital Directors who are often replaced when there is a change of Minister. Frequent turnover at so many levels of the ministry weakens its institutional memory and leadership capacity.

The current Prime Minister has established a Health Reform Task Force comprised of high level officials and senior medical doctors. There is no legislation that mandates its existence, or establishes its authority and purpose - it serves the Prime Minister as an ad hoc advisory body. Nevertheless, this task force presents an opportunity to get important health issues on the national agenda and sets a precedent for the establishment of a forum at which high level decision makers gather to discuss health reform issues, strategize and set priorities, coordinate activities and review implementation.

Highly-centralized decision making, poor communication, and inadequate reporting systems both within the MOH, and between MOH staff and staff of other health sector institutions, such as the National Center for Quality, Safety, and Accreditation (NCQSA,) National Center for Continuing Education (NCCE) and HII, limit priority setting, development and dissemination of regulations, needs-based budgeting, management and oversight. Currently MOH decision-making occurs at the highest level, including only the Minister and his political appointees, and many of the new laws require that even fairly routine decisions be made by committees chaired by the Minister. While the MOH is responsible by law to develop policies and regulations, they are not communicated and understood by technical staff and, in turn, incorporated into regulations, plans and procedures. In addition, information is not routinely used to improve policy-making and planning, monitor implementation and strengthen accountability. However, recent improvements in the structure and functioning of the MOH M&E Directorate, including development of a routine reporting system, are important first steps in developing effective management systems to strengthen MOH oversight.

The MOH has not exerted its authority and fulfilled its legislated mandate to issue nationally-accepted standards and indicators for health care delivery. The NCQSA has developed indicators for hospital accreditation, which are not currently disseminated or widely used. The HII uses indicators for primary health care in its contracts with HCs. The MOH has yet to take the lead and implement a process to assure that these standards and indicators are technically-sound; appropriate and

feasible to use within the MOH context; and nationally-accepted. This has resulted in confusion about which indicators to use and how they should be implemented. The NCQSA could potentially serve as a technical resource for the development of standards and indicators while the MOH could be responsible for their dissemination and implementation. The MOH and the NCQSA could also work with HII to improve use of their contracts to provide incentives for performance improvement.

Clearly defined roles, responsibilities and communication channels as well as regular meetings and reporting requirements are needed to improve implementation, accountability and responsiveness. The MOH must lead the sector, advocate effectively and mobilize institutions, including the NCQSA, NCCE, HII and international donors, to support and pursue its objectives. Reporting also needs to be developed to increases transparency and improve accountability to the sector's most important stakeholders, namely patients and the public. This should include efforts such as implementing public relations campaigns, publicly posting MOH annual reports and/or issuing newsletters on important issues or new initiatives.

Table 1 summarizes the gaps in governance and leadership in the health sector as well as proposed recommendations as discussed above.

TABLE 1: MAJOR GAPS IN HEALTH SYSTEM GOVERNANCE AND LEADERSHIP (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Developing National Strategic Policy Framework	• MOH has drafted National Health Strategy 2007-2013 but has not provided strong leadership for its dissemination and implementation	• No clear mechanism to hold the MOH accountable for providing leadership	• The National Strategy has identified appropriate priorities that respond to the needs and has become a reference point for planning	• Support development of a health reform steering committee as a permanent body, to increase oversight
Priority setting and policy making	• Minister sets priorities and makes policies. Highly-centralized decision making limits implementation of policies	• MOH not held accountable for communicating priorities and implementing policies	• Priorities are responsive to national needs but are not being implemented.	• Support the health reform steering committee to strengthen MOH leadership and increase accountability
Provide regulations, budgets, incentives and oversight to ensure implementation	• MOH capacity to provide leadership is limited • HII developing processes that will be based on needs rather than inputs, but, will take time • NCQSA and MOH do not collaborate to implement standards. HII steps in to fill the void. Institutional rivalries develop.	• MOH is not held accountable for lack of leadership in develop and implementing regulations.	• Lack of clarity on roles and responsibilities and poor coordination limit responsiveness. MOH needs to take the lead and advocate other organizations, HII, NCQSA, NCCE, to pursue its objectives.	• Support the health reform steering committee as a forum for institutions to improve communication, clarify roles and responsibilities, coordinate activities and increase accountability
Coalition building coordination among health institutions; with donors,	• Unclear roles and responsibilities and poor communication hinder coordination	• No mechanism for coalition building and coordination		• Support the health reform steering committee as a forum for coordination and coalition building • Support secretariat to

TABLE 1: MAJOR GAPS IN HEALTH SYSTEM GOVERNANCE AND LEADERSHIP (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
other stakeholders				strengthen capacity for coordination, planning and advocacy • Support the MOH to improve internal and external communication and coordination

3.2 STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY

The NCQSA and the NCCE were created to strengthen and support the MOH in efforts to improve quality. The NCQSA is mandated to improve quality of care and implement a process for accrediting hospitals. The NCCE assures the quality of continuing medical education to strengthen the capacity of health care providers to provide quality care. While the roles of the MOH and these supporting institutions are defined in various laws, in practice there is confusion about responsibilities, duplication of effort and poor coordination of activities.

As discussed above, the MOH has not fulfilled its role to develop, disseminate and implement standards. The NCQSA has developed a national quality strategy well as a system for accreditation of hospitals in order to ensure a standard level of care. However, the NCQSA has a staff of less than twenty and insufficient capacity to implement these efforts. The MOH has not clearly defined the role of the NCQSA vis a vis its own legislated mandate to provide national standards and ensure quality. The HII has developed quality indicators for primary healthcare that it includes in its HC contracts. While these indicators are intended to serve as incentives to improve quality of care, in fact, they are better designed to improve cost-effectiveness. As the HII progresses with its contracting of hospitals it will play an increasingly important role in improving the quality. Opportunities for using the HII contracting mechanism as a means of providing incentives to improve quality through initiatives such as continuous quality improvement should be explored. HII needs technical guidance from both the MOH and the NCQSA and the MOH needs to lead an effort to clearly define roles and responsibilities and develop and implement indicators and processes to improve quality.

Both the M&E Directorate and the Institute for Public Health play important roles in informing policymakers and other stakeholders of the key issues that need to be addressed by the health sector. Their roles and responsibilities will need to be clearly understood and their efforts coordinated. The M&E Directorate has successfully coordinated a collaborative effort involving the HII, MOH, Institute of Public Health (IPH), NCQSA and NCCE, to generate and present its first round of annual reporting on the performance of the health system. This reporting will be essential to monitoring performance and informing policymaking and planning. The IPH analyzes epidemiological data, as well as international research, to identify key issues and has recently formed the National Council on Public Health to advise high-level policy makers on key issues. The M&E Directorate and the IPH will need to build their capacity to develop communication strategies that identify key decision-makers, delineate their information needs, strategize ways to present needed information to them and ensure that data informs health sector planning and decision-making.

In order to improve the knowledge and skill of health providers the Basic Health Law requires health professionals to earn 150 credits in continuing medical education (CME) to be re-certified and re-licensed. The NCCE has developed a registry of health workers and maintains a database to track health professionals' CME credits earned and recertification status. The Order of Physicians also maintains a registry of certified physicians in the country. The NCCE is mandated to accredit CME courses in an effort to ensure a minimum standard of quality. It also supports a website to inform

health providers around the country of upcoming courses and the number of credit hours they are worth. Many of the courses are offered through the internet. While the NCCE seems to be fulfilling its role in accrediting training and tracking provider credits earned, it has not been able to identify sufficient courses to meet current training needs, especially in much-needed subjects such as health management. In addition, the MOH has not developed and funded courses to meet particular gaps in the skills of health workers and ensure that workers in remote regions of the country have equal access to training opportunities. Some providers find themselves taking courses, regardless of the relevance of the subject matter to their work, just to qualify for recertification. The Order of Physicians and the Order of Nurses will be important groups to advocate for improvements in availability of CME opportunities. Also, improved information sharing and stronger coordination between the NCCE, the MOH, the Order of Physicians and the Order of Nurses to identify training gaps, develop training courses, explore and develop innovative long-distance training opportunities, and advocate for funding to better meet training needs is needed.

Table 2 summarizes the gaps in standards and processes to ensure and improve quality in the health sector as well as proposed recommendations as discussed above.

TABLE 2: MAJOR GAPS IN STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Develop, disseminate and implement Standards, protocols, clinical guidelines to improve quality	• MOH and NCQSA have limited capacity to implement quality improvement • HII has developed indicators for its HC contracts but they do not really measure service quality	• No mechanism for ensuring accountability • HII needs technical guidance from the MOH to improve its incentives for quality improvements	• MOH, NCQSA are not responsive to HII needs • MOH is not responsive to patient needs	• Support leadership of MOH to coordinate with NCQSA and HII to develop better incentives that promote quality of care
Establishment and implementation of M&E system (info from M&E Vision and Framework, March 2010)	• M&E Directorate completed first round of reporting. Needs continued capacity building to increase reliability, quality and timeliness of data	• No clear lines of communication for M&E Directorate to present its reports	• M&E Directorate responding to need for M&E system	• Continue to strengthen the capacity of the M&E Directorate and the M&E Core and Reference Groups
Analyzing and Using data to inform policy making	• M&E Directorate weak in analyzing data and presenting it to decision makers	• No current mechanism for M&E Directorate to analyze and present data and coordinate with IPH in identifying key issues		• Strengthen capacity of M&E Directorate and IPH to conduct advocacy, for both policy makers and the public
Accreditation of Hospitals	• MOH and NCQSA weak in implementation of accreditation process	• No mechanism to ensure accountability	• Accreditation process too burdensome to meet needs of hospitals	• Facilitate better bilateral coordination between MOH and NCQSA
Registration, licensing and recertification of health providers	• NCCE maintains registry and recertification database	• MOH does not require NCCE to share information or assist it in	• NCCE is not meeting training needs of health professionals	• Facilitate bilateral sharing of information and coordination

TABLE 2: MAJOR GAPS IN STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
	• NCCE cannot meet training needs of providers	planning for manpower and training needs	• NCCE not meeting information needs of MOH	between NCCE and MOH
Continuing Medical Education	• NCCE can manage accreditation system • MOH cannot mobilize sufficient funds to meet training needs	• MOH does not hold NCCE accountable to identify or meet priority training needs.	• CME system does not fully respond to needs of health system	• Support MOH to prioritize training needs and advocate for funding to support training

3.3 HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT

There does not seem to be a clear strategy for planning and distribution of hospitals, and it seems different approaches are being pursued. One approach is based on the traditional role for the MOH as the central planner for where hospitals are located, what services they provide, how staffing is structured, and the funding they receive. Although studies to rationalize the hospital sector have been conducted, there does not appear to be enough political will to implement these plans. Another approach envisions that with autonomous hospitals and HII-established reimbursement fees for hospital services, the rationalization process will happen more spontaneously as hospitals become unsustainable based on the income they generate, and are forced to cease operations. The MOH does not seem to have the technical or political capacity to develop and implement such a coherent and transparent strategy for reorganization of the hospital sector.

Decision 1661 and Decision 140 divided funding for hospitals between MOH and HII, with MOH responsible for hospital investments, while HII is responsible for funding operational costs. These decisions also stipulated hospital budgets for 2009 and 2010, emblematic of the degree of centralization in the Albanian health system. Since 2010, HII has contracted with hospitals to provide services, although unlike for PHC, there are no incentive payments based on quality of service volume. Hospital budgets and hospital staffing seem to be static from year to year. Additional financing to hospitals comes in the form of user fees collected, normally referred to as "secondary income." This income has been increasing in recent years.

As part of the mandate established in 2009 for HII to finance hospitals, HII has enacted many improvements in record-keeping at hospitals. Beginning in 2011, all hospitals implemented a Unique Medical Record for each patient, with data on diagnosis, treatments, and medicines prescribed. These data systems could potentially play an important role in providing data for hospital management, and from the perspective of HII, for improved cost efficiency.

More guidance is needed to clarify the authority given to hospitals as independent institutions, as well as to clarify the structures that govern how this authority should be exercised. Hospital management has authority only to make minor changes to the hospital budget, and only with HII approval. If they are to function as independent institutions, the authority to restructure budget, shifting personnel budget to investments, for example, should be allowed with specific guidance on oversight structures. Hospital managers are appointed by the Minister of Health, and not necessarily in a transparent, merit-based process. There is not a clear structure for external Board oversight, or regional and district health authority oversight of hospitals. Hospitals do provide data regularly to HII (admissions, discharges, diagnoses, medication costs, etc) but it seems that regular procedures for oversight and review are under development. Clear guidance for hospital managers on the scope of their authority, structures and responsibilities of oversight boards, together with indicators in HII contracts that better target quality improvements, can increase efficiency and quality.

The responsibility of district and regional health officials in hospital oversight is unclear. They are not involved in supervision of hospital services, staffing, or budget development. Certainly with the limited management skills within hospitals, district and regional health officials could serve a useful function in management and oversight of hospitals. Further review is needed to analyze appropriate functions at national and subnational levels of the health system more broadly, and the role of these subnational offices in oversight and coordination.

Table 3 summarizes the major governance gaps in hospital organization, operations and management, along with proposed recommendations as described above.

TABLE 3: MAJOR GAPS IN HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Planning for hospital sector overall	• There is not a coherent policy for hospital distribution • The MOH is not fulfilling its function as coordinator	• MOH is not held accountable for this function	• There is no mechanism to ensure stakeholder input (particularly the general population and communities) in hospital planning	• Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and Health Insurance Regional Directorates (HIRD) • Support stakeholders to develop coherent policy/plan for the hospital sector
Hospital financing	• HII has made progress toward case based financing, but additional technical assistance may be needed			• As recommended by the EEHR Project HII Review, support HII to implement case-based payment
Hospital management	• Authority of hospitals (and HCs) as autonomous institutions is unclear • Hospitals do not have guidance or skills to establish hospital Boards and define their functions	• No mechanism in place to hold hospital managers accountable • Hospital managers are political appointees so accountability may be distorted	• No procedure in place to respond to external stakeholders, although patient satisfaction surveys are planned	• Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and quality • Support development of guidance to clarify the scope of authority of key actors
Monitoring and oversight of services	• MOH capacity to monitor and oversee hospitals is weak	• No mechanism to hold MOH accountable		• Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII

3.4 FINANCING AND HEALTH INSURANCE

HII estimates that there are approximately 1.2 million registered insured (carrying an insurance booklet.) Of the registered insured, the large majority are pensioners for whom no contributions are required. The HII is responsible for registering the insured individuals, but responsibility for collection of premiums is split between the General Tax Directorate (for those formally employed),

the Social Insurance Institute (SII) (for farmers), and the HII (for individuals making voluntary contributions.) Many individuals that contribute to the insurance scheme through the Tax Directorate or SII do not register at HII with documentation of their contributions to receive an insurance booklet. Health centers and family doctors, as part of their contract with HII, are meant to encourage patients and their catchment population to register with HII. Nonetheless, insurance booklet holders represent approximately 42% of the population, based on 2008 LSMS data.

Until there is reliable data on who is insured, and the rate of insurance coverage is increased significantly, HII cannot move toward true capitation payment for PHC. Without capitated payment, and provider choice, the goals of improved quality and efficiency will not be realized. Further, without reliable data on the insured, it is difficult to decipher the reasons why the uninsured do not contribute, or investigate alternative mechanisms for insurance contribution.

As stipulated in the Health Insurance Law, both MOH and HII have responsibility for defining the benefits package for the insurance scheme. The benefits package for PHC is well defined, but the plan for defining the package of services at hospital level is less clear. Because there was little data to support decision making, HII funding to hospitals (which began in 2010) is solely based on historical budgets. Data is not readily available on cost of services or incidence of use. HII has implemented new data collection systems in the last two years, including forms to generate a unique medical record per patient, which provides data on the diagnosis, as well as all of the treatments and drugs/supplies provided. This data will be critical as HII transitions hospitals from budget-based to case-based funding.

The MOH and NCQSA have been working to develop appropriate protocols to support full costing of services, as part of their plan to develop the hospital benefits package. Protocols for approximately 200 diseases were developed, but not disseminated. While these protocols may be clinically appropriate, they may not be realistic given available resources.

HII does envision a goal of contracting with high quality, cost effective providers, including a mix of public and private providers, providing insurance holders provider choice, particularly in urban areas. There are two barriers to achieving this vision – HII does not have the authority to stop funding a facility, and MOH's ability to oversee and coordinate with the NCQSA and NCCE to ensure quality services is limited.

The MOH is clearly the institution with responsibility for health provider quality, with Decision 10 107 providing it authority to provide standards and supervise their implementation. However, the MOH does not have sufficient resources, technical capacity, or leverage over affiliated institutions such as the NCQSA, to fulfill its responsibility. In practice, HII has moved ahead within its PHC contracts to hold HCs accountable to standards that it has defined, although these mechanisms are not yet in place in its contracts with hospitals. While these HC standards are often referred to as performance and quality indicators, in reality, they are more oriented toward cost control and efficiency.. HII has put in place the systems to allow effective oversight of provider quality – the gap appears to be related to the lack of formal mechanisms in place to ensure that MOH and other relevant institutions provide input to the indicators set in the HII contracts with providers.

According to the Health Insurance Law, HII is governed by its Director and Administrative Council, which includes the Minister of Health, Minister of Finance, Minister of Social Affairs and Equal Chances (or their representatives,) as well as other relevant institutions. The Administrative Council is charged with internal oversight, including approving the HII Director, budget, and organizational structure, as well as criteria in contracts with providers, etc. The primary need for external oversight was not to ensure responsible HII management (which is under the purview of the Administrative Council) but to ensure that the insurance scheme is meeting its goals of universal access, cost efficiency, and quality improvement. This oversight should be one part of the function of an oversight body tasked with leadership and oversight of the whole health sector. While HII seems capable of implementation once design elements are clear, neither the MOH nor another institution seems to be monitoring whether the insurance design is meeting the broader objectives of the health sector.

Table 4 summarizes the major governance gaps in the area of financing and health insurance, along with proposed recommendations as described above.

TABLE 4: MAJOR GAPS IN FINANCING AND HEALTH INSURANCE (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Enrolling eligible population and collecting premiums	• HII has developed adequate operational systems for insurance registration, but has not focused on increasing the insurance coverage rate	• HII has no leverage to induce better cooperation from Tax Directorate of the Social Insurance Institute • While PHC providers are responsible for encouraging insurance registration, they are not held accountable	• Although health insurance is compulsory, there are no strategies in place or actions planned to tackle the low registration rate (approx. 42%)	• Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants • Support HII at central level in discussions with other government agencies to obtain data they need on contributors
Defining hospital benefits package	• HII and MOH do not appear to have a clear plan for how the package of hospital services will be developed • MOH has not taken responsibility for policy guidance on allocation of HII expenditures between PHC and hospital care, or between medicines and other costs	• It is unclear who should hold the MOH and HII accountable for timely and reasonable action	• Patients are not included in discussions regarding benefits package	
Establishing payment terms for providers	• According to the EEHR HII Review[1], HII does not have sufficient capacity to manage a transition to case-based payment for a package of hospital services without external assistance	• Despite many accomplishments, HII is not held accountable for faster progress in moving toward service-based payments to providers	• MOH does not provide input on whether HII performance/quality indicators are appropriate • There are no mechanisms for aggregating provider feedback or concerns regarding HII's contracts	• Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other payments for non-registered patients
Selecting providers	• MOH, together with NAB and NCQSA, are responsible for accrediting providers, but capacity within	• HII is directed by the Health Insurance Law to select providers but does not have authority		

[1] Purvis, George, Ainura Ibrahimova, and Flora Hobdari, July 15, 2011. *Albania Health Insurance Institute Review: Challenges and Opportunities, Technical Report*

TABLE 4: MAJOR GAPS IN FINANCING AND HEALTH INSURANCE (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
	MOH to coordinate and lead this effort is weak • MOH capacity to guide policies related to funding basic health services in sparsely populated areas, irrespective of efficiency considerations, is weak	to NOT contract with a public facility		
Overseeing provider quality	• HII has developed good systems for provider oversight, but does not have sufficient technical guidance to ensure its contracts sufficiently reward quality • MOH has limited capacity to enforce quality standards	• There is no mechanisms to hold MOH accountable for this function	• There are no mechanisms to ensure that institutions such as HII or NCQSA are responsive to MOH concerns	• Improve the capacity of MOH as leader and coordinator of quality issues
Review and pay claims				
Oversight of Health Insurance Fund	• The MOH is responsible for oversight, but exerts little leadership and authority over HII or other relevant organizations • In addition to leadership and policy setting, MOH capacity in coordinating the relevant actors is also weak	• HII's Administrative Council oversees the functions of HII, but there is no institution that oversees whether the insurance scheme is achieving the goals of universal access or financial risk protection	• There do not appear to be any mechanisms to collect feedback from patients and the general population	• Support MOH and HII to set clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency • Support joint planning between MOH and HII to implement reforms, particularly related to the benefits package and provider quality

4. CONCLUSIONS

Albania has made significant progress in its transition to single payer health financing with universal coverage for all, using provider contracting mechanisms to ensure high quality, cost effective services. It is an ambitious undertaking to ensure high quality services for both rich and poor and strong oversight is critical to ensure appropriate implementation that supports achievement of the reform goals.

To support this transition, the MOH must evolve from its historical role as provider of health care to steward, policymaker, coordinator and advocate. While no longer controlling the resources, the MOH continues to be responsible for providing oversight and ensuring provision of quality health services. The MOH has struggled with fulfilling this new role, and it is clear capacity building is required throughout the institution. An ongoing culture of centralized, top-down authority that leaves staff feeling un-empowered further contributes to the lack of technical capacity. There is insufficient coordination and communication within the MOH, leaving staff with a lack of clear vision and direction, and limiting their ability to influence and mobilize others.

While at central level the MOH is still responsible for developing policies that they do not have budget or authority to implement, the roles and responsibilities of the regional and district health authorities are even less clear. They no longer develop budgets, supervise staff, or oversee hospitals. Analysis of the appropriate functions at central and subnational levels in overall oversight and coordination is needed to define an appropriate role for regional and district health authorities.

At the same time, several auxiliary institutions (HII, NCQSA, NCCE, IPH) have emerged with strong leaders, overlapping mandates, and/or external support that challenge the MOH authority. For the most part, these organizations have been competent in carrying out their specific functions. At the regional and district level, HII is the most visible health authority, conducting regular HC supervision, reimbursing pharmacies, and providing incentive payments to HCs. What is lacking is oversight to ensure that the package of individual functions and coordination of efforts, as currently designed, are leading to better health system performance.

The legislation (Health Insurance Law, Basic Health Care Law, Law on Public Health) recognizes the MOH as the institution responsible for policy, oversight and coordination of the sector. However, lacking are the formal institutional relationships and managerial systems that allow the MOH to fulfill its role. Auxiliary institutions (HII, NCQSA, NCCE, IPH) do not have clear, mandated responsibility to report to the MOH, in a way that recognizes the MOH's authority as the leader and overseer for the sector. Without such mandates, which may need to come in the form of national legislation, the MOH has little leverage to ensure that all institutions work collaboratively toward a common vision and fulfill their responsibilities. One possibility for developing a mechanism to strengthen managerial systems is the formation of a permanent, mandated, sector-wide health reform steering committee that would strengthen the oversight role of the MOH. It could provide a forum for health sector institutions to clarify roles and responsibilities, review strategies, coordinate activities and hold one another accountable for fulfilling their responsibilities. Another possibility for strengthening the oversight relationship could be if the MOH were given oversight responsibilities such as review of annual progress reports or resource allocations to auxiliary institutions in the sector.

Throughout the sector, there is not clear alignment of institutional relationships and incentives to hold organizations accountable for fulfilling their mandated responsibilities. One specific gap that arises from the lack of coordination is a strategy for integrating the institutions' individual functions (financing, facility accreditation, continuing medical education, and oversight and supervision) to drive improved quality. This lack of coordination limits the potential impact of each of the functions and wastes limited resources. There is also not an easy answer as to how to help the MOH better understand the importance of its oversight role and hold it accountable for fulfilling its functions. To this end, the role of civil society and non-governmental stakeholders, including patients groups, provider groups, academic and research organizations, and the media, must be explored further.

Also, including representatives from these groups in the Health Reform Steering Committee could strengthen their advocacy role in influencing policymaking. The area of service quality may be a good starting point for EEHR focus, because health institutions have already begun to address quality, there is relatively less overlap among the various institutions, and it is an area where it may be possible to generate civil society interest and promote their participation in advocating for health reform.

Specific recommendations are provided below to improve governance and to ensure that key functions are carried out. They were made with consideration of GOA, USAID and EEHR interests, although a few may be beyond the scope of the EEHR project. The insufficient authority of the MOH is a root cause of many problems and is not easily addressed. A combination of capacity building, changes in institutional relationships that support the MOH's position of authority, and stronger mechanisms outside the MOH to hold it responsible is needed. Supporting legislation related to these matters may be effective, but may not be feasible nor within the scope of EEHR. Recommendations to address governance gaps are organized within each of the four functions below.

4.1 HEALTH SYSTEM GOVERNANCE AND LEADERSHIP

- Support development of a health reform steering committee as a permanent body: to increase accountability of implementing agencies; to provide a forum for health sector institutions, including non-governmental stakeholders, to improve communication, clarify roles and responsibilities, coordinate activities and advocate for policy reform.
- Support the M&E Directorate to serve as secretariat to the health reform steering committee to strengthen capacity for coordination, planning, advocacy and use of data to inform policy making and planning.
- Support the MOH to improve internal and external oversight, coordination, advocacy and communication.
- Assess, identify and support civil society organizations (CSOs) that could play a positive role in holding the MOH and other institutions accountable.
- Analyze the potential role for EEHR in supporting legislation to enforce the health reform steering committee or to enforce MOH authority and oversight with specific reporting relationships with auxiliary institutions. EEHR might identify potential champions who could take on this advocacy role, and provide support.

4.2 STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY

- Support coordination between MOH, NCQSA, NCCE and HII toward the goal of improving quality of care, including development and implementation of an integrated strategy including financing, facility accreditation, continuing medical education, and oversight and supervision to drive improved quality. This common effort could also serve as the basis to build MOH leadership, strengthen institutional relationships, and improve accountability. EEHR might pilot this process at the regional level to demonstrate impact and develop best practices, while also serving to define appropriate roles for regional health authorities.
- Continue to strengthen the capacity of the M&E Directorate.
- Strengthen capacity of M&E Directorate and IPH to conduct advocacy, for both policy makers and the public.
- Facilitate better bilateral coordination between MOH and NCQSA by developing and implementing a national quality strategy that clearly defines roles, responsibilities, reporting relationships and promotes accountability.
- Facilitate bilateral sharing of information and coordination between NCCE and MOH. This might include encouraging the NCCE and the Directorate of Human Resources and CME to meet regularly and develop and implement annual training plans.

- Support MOH to prioritize training needs and advocate for funding from the MOF and international donors to support training.

4.3 HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT

- Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and HIRDs. EEHR might consider seconding a staff person that mentors the Hospital Directorate to: develop a proposal for discussion of specific roles, authority, functions and inter-relationships of various institutions; strengthen skills in leading multi-institution meetings and facilitating agreement and follow-up; develop strategy to advocate for additional resources to support activities of all institutions. EEHR may also support a consultant to facilitate such discussions.
- Support stakeholders to develop and implement a coherent policy/plan for the hospital sector. Because one of the key constraints is political willingness to act on hospital rationalization plans, EEHR focus may be in the areas of political analysis and strategic communications to manage negative public reaction.
- As recommended by the HII Review, support HII to implement case-based payment for hospitals.
- Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and structures in hospitals, and supporting self-assessment and problem quality improvement in preparation for NCQSA accreditation.
- Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII.

4.4 FINANCING AND HEALTH INSURANCE

- Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants. EEHR might also facilitate collaboration with CSOs and media organizations to support this effort.
- Support HII at central level in discussions with other government agencies to obtain data they need on contributors.
- Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other payments for non-registered patients
- Improve the capacity of MOH as leader and coordinator for quality-related issues in health insurance. Possible activities might include articulating a national strategy to integrate the functions of financing, facility accreditation, CME, and oversight and coordination, with clear roles for all institutions and subnational entities.
- Support MOH and HII to set and disseminate clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency. Activities may include facilitating senior level agreements between MOH and HII, and supporting dissemination of such agreements throughout the respective organizations and the health system.
- Support joint planning between MOH and HII to implement insurance reforms, including an agreed approach and detailed workplan toward case-based payment and improving provider quality.

The recommendations offered here aim to address gaps identified in the areas of capability, accountability, and responsiveness that hinder effective implementation and full potential of the legislated health reforms. While these were developed in light of EEHR's project interests, final selection of activities to be pursued must made considering a complementary set of strategies related to improving governance, support to HII, as well as support of the health sector M&E system.